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The development of the examination for membership of the Royal College of General Practitioners

Extracts from the Provost's Address to the Northern Ireland Faculty, 5 October 1987.

I B Moran

THE EARLY YEARS

When the College of General Practitioners was formed in 1952 criteria for Foundation Membership included length of service in general practice and a commitment to continuing education. Membership was somewhat later made available to those whose application was supported by sponsors testifying to the applicant's high standards of practice. Some candidates had to submit to an interview: all had to give an undertaking to uphold and promote the aims of the College.

In 1954 an examination committee was established and eleven years later in 1965 a Court of Examiners was approved and the first examination was held. The aim of the examination was to test the competence of the ordinary general practitioner in his work by assessing his or her knowledge of the details of clinical medicine and the ancillary services.

Five sat and four passed that first examination from the whole of the British Isles. From 1965 – 1967 few candidates sat the examination and the November 1967 examination was cancelled because of lack of support. At the annual general meeting of the College in 1967 it was decided that the normal route to membership would be by examination only. The first compulsory examination for entrance to the College was held in November 1968. There were 32 candidates. In 1969 71 candidates passed and in 1970 67 candidates were successful. In 1970 the MRCGP became a registrable qualification with the General Medical Council.

The great development of the examination coincided with the introduction of vocational training. When vocational trainees became an increasing proportion of candidates the original aim of the examination "to test the competence of the ordinary general practitioner in his work" was revised in 1980 "to assess the knowledge and competence appropriate to the general practitioner on completion of vocational training".

ASSESSMENT OF GENERAL PRACTITIONERS

Assessment is defined as being "measurement by as objective a method as possible of the learning achieved by the learner". There are immense difficulties in devising methods of assessing a general practitioner on completion of vocational training. These difficulties include establishing what is already known by the learner before entering general practice, measuring any change during the training course and defining precisely what has to be learned.

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Terminal assessment, as in the FRCS, has been used for many years as an indicator of higher medical training. In this present decade the MRCGP is being used in a similar way. The great weakness of terminal assessment, from a training point of view, is that if it produces a negative result it is too late to give the individual concerned a chance to take remedial action.

THE DEVELOPING YEARS

The three year vocational training scheme became mandatory for general practice on 16 August 1982. As will be seen from Fig 1, making the examination compulsory for admission to the college had little effect on the rate of increase of college membership; the major influence was the introduction of mandatory vocational training.

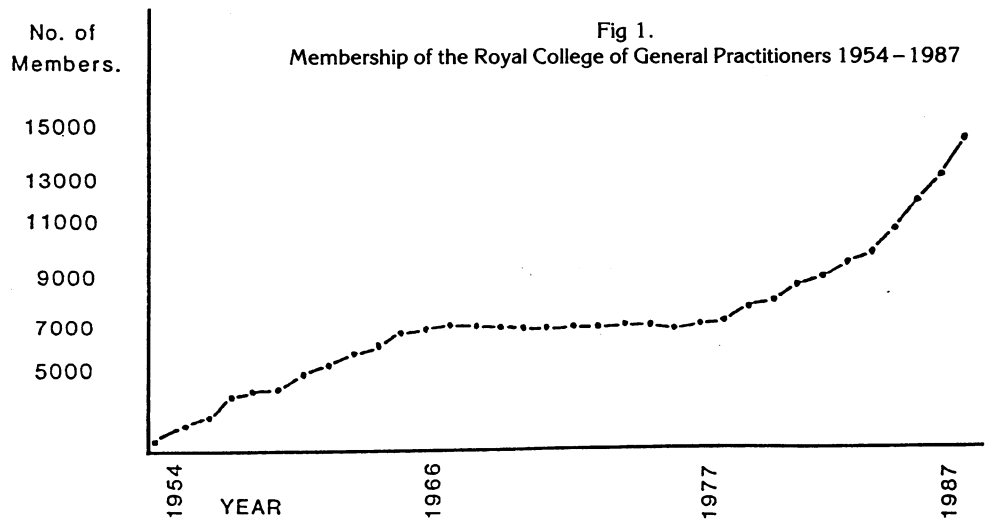

Fig 1.
Membership of the Royal College of General Practitioners 1954–1987

The number of candidates has risen from about 1,000 per year to nearly 2,000 per year since the introduction of vocational training. The pass rate has remained relatively constant at about 70% (Fig 2).

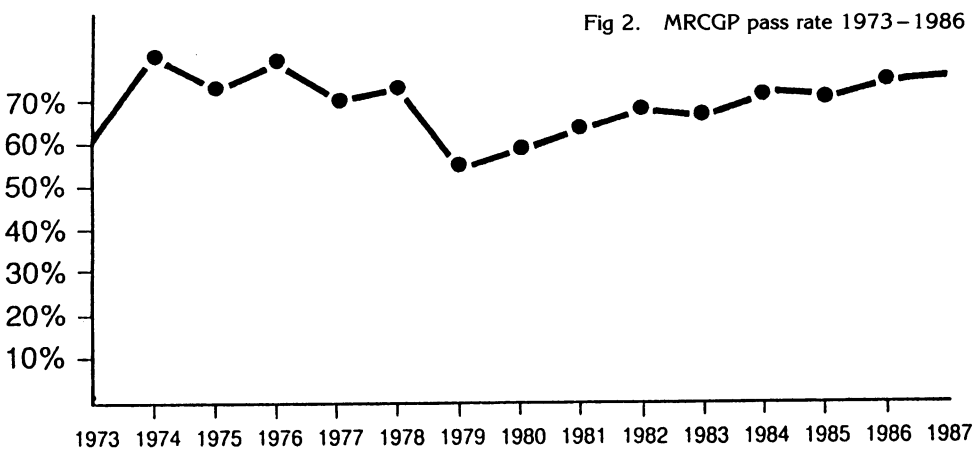

Fig 2. MRCGP pass rate 1973–1986

THE NORTHERN IRELAND SCENE

The number of candidates sitting in Belfast since the first MRCGP written examination was held here in 1971 is shown in Fig 3. The total number is 601 of whom 419 passed, giving an average pass rate of 69% which is about the national average. The top 2·5% of the pass list are awarded distinctions. From 1982–1986 we had 15 candidates who obtained distinction, which is well over twice the national average. Training for general practice became mandatory in 1982 and our selection system became highly competitive.

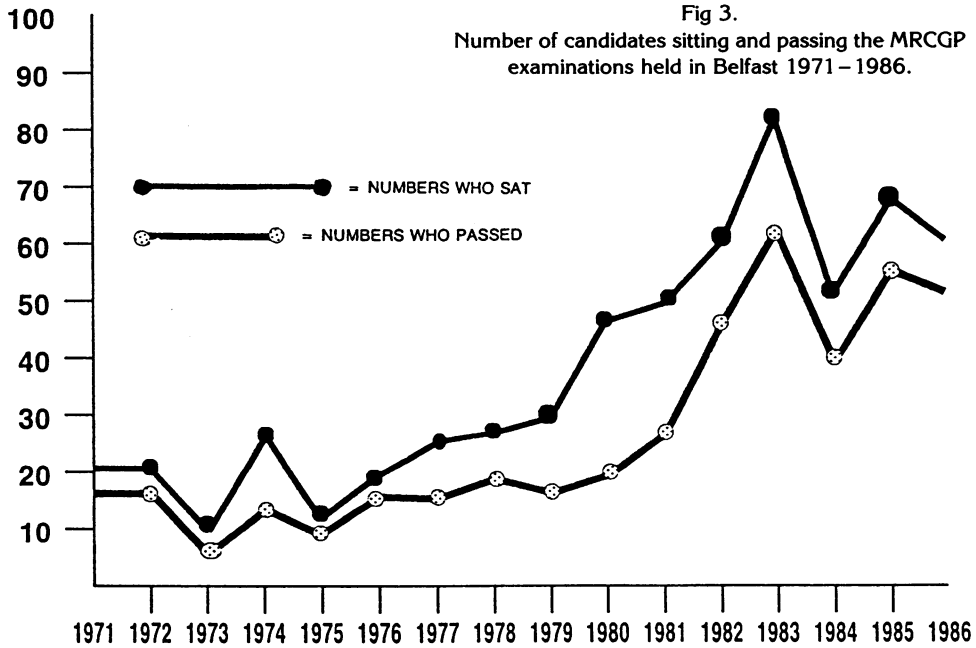

Fig 3.
Number of candidates sitting and passing the MRCGP examinations held in Belfast 1971–1986.

NI GENERAL PRACTITIONERS AND COLLEGE MEMBERSHIP

A previous study [1] recorded the progress of the college in Northern Ireland up to 1978. A comparison of the end point of that study and what has happened in the next eight years is shown in the Table. At the end of 1986 45% of the 33,000 general practitioners in Great Britain were college members. In Northern Ireland 55% of general practitioners who are in active practice are college members.

TABLE

Increases in college membership in Northern Ireland

	All general practitioners in Northern Ireland		*Fellows / Members / Associates of the Royal College of General Practitioners*	
Area Board	*1978*	*1986*	*1978*	*1986*
Eastern	309	381	126	278
Northern	167	202	57	112
Southern	127	171	27	89
Western	114	149	17	61
Total	717	903	227	540

Five points are highlighted by the RCGP examination:

Should the Joint Committee on Postgraduate Training for General Practice have a terminal assessment at the end of vocational training, or should all who complete the mandatory three years training be automatically eligible to practice, even though the MRCGP examination demonstrates that a tiny number of these know very little of what general practice is about? That is a problem for the Joint Committee: it should also be of concern to any general practitioner interested in maintaining standards.

Should passing the membership examination give the right to full membership of the college or should there be a diploma followed by a form of in-practice assessment leading to full membership? In other words should we have a smaller, more exclusive college?

Should there be an alternative route to membership? The present system has lasted since 1968. Should it always continue that way?

Should the college examination continue to be peer referenced as at present or should it be criterion referenced? At present, the college examiners, who are all active in practice, set the examination papers, construct marking schedules and apply them to the candidates' answers. In pairs, they assess the candidates in each of the two orals, judge the value of the answers and mark independently and they then agree a final overall mark. Criterion referencing implies there is a defined core content of general practice. No-one yet has produced such a definition. With the development of general practice in relation to hospital outreach through community paediatrics, and the introduction of psychiatric, diabetic and cardiac nurse specialists, keeping the criteria up-to-date and uniform would also present a problem. A further difficulty with criterion referencing is that if everyone meets the criteria there is 100% pass rate. If everyone does not there is a 100% fail rate. How would medical politicians react to that situation?

Lastly, should the membership examination have a clinical component? Any examination must be both valid and reliable. Validity relates to the extent to which the examination measures objectives appropriate to the tasks. It samples the attributes of the candidate over a whole range of topics. This is more important in general practice than in any other branch of medicine. Reliability relates to the consistency with which similar results are produced when candidates are repeatedly tested using the same technique or when the same characteristic is evaluated by using a variety of problems. The MRCGP examination has achieved a very high level of validity and reliability in assessing the attributes required of a doctor completing vocational training and about to enter practice as a principal.[2] If one introduced a clinical test it should be possible to make it satisfy validity. But what about reliability of the assessment in different centres, such as Edinburgh, Cardiff, Liverpool, London, Birmingham or Belfast, in examining 2,000 candidates per year? A major study has been commissioned by the college to test the reliability of an objective-structured clinical examination and college examiners are eagerly awaiting the outcome of this study.

I am grateful to Mr Tom Dastur, examinations administrator, RCGP, for access to membership data: to my colleagues on the panel of examiners who have taught me so much since I joined them in 1978: to Dr K Connolly, my partner, who has allowed me time off twice yearly to attend orals: to my wife and family who allow me to become a hermit four weekends a year while marking papers.

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